Patient Account #: _____

Urgent Orthopedic Specialists
4304 Andrews Hwy Midland, TX 79703
Phone: (432) 520-3020 Fax: (432) 699-1981

Donald W. Floyd, MD David A. Hester, MD
Bryan Allen, NP Angie Gonzales, PA
Stephen Dodd, PA Mike Taylor, PA

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

I request and authorize ☐ Urgent Orthopedic Specialists ☐ **Other**: _____
To release healthcare information of the patient named above to:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Complete medical Records ☐ Office dictation only ☐ Operative Reports
☐ Lab and X-ray Reports ☐ X-rays or MRI ☐ Other:_____

Purpose of Release:

☐ Continued Care ☐ Insurance ☐ Attorney
☐ School ☐ Personal Review
☐ Other: _____

Release from Liability: I release and agree to hold harmless Urgent Orthopedic Specialists (UOS) or releasing facility and its agent's representatives, and employees from any liability associated with the release of confidential patient information in accordance with this authorization.

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to UOS, 4304 Andrews Hwy, Midland, TX 79703. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature _____ Date Signed: _____

Representative Signature: _____ Date Signed: _____

Please Note: Copy Fee May Be Charged For Medical Records